FORM HR-RM 1 (9-1-53)
Hall of Records Commission

REQUEST FOR RECORDS RETENTION FILE

To Be Submitted to the Records Management Division
Hall of Records Commission

SCHEDULE NO. 276
PAGE NO. 1.

1. Requesting Agency	2. Division or Bureau of Requesting Agency
DEPARTMENT OF MENTAL HYGIENE	ALL MENTAL HYGIENE HOSPITAL UNITS

3. Authorization Requested (Check only one of the squares below).

A ☐ Dispose of present accumulation. No additional accumulation is anticipated. Records have ceased to have value to warrant retention.

B ☒ Establish retention schedule for records for which there is a continuing accumulation. The records will cease to have value to warrant their retention after the period of time indicated.

C ☐ Microfilm and destroy originals. Originals if not microfilmed would be retained for the period of time indicated.

4. Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

PATIENTS' MEDICAL RECORDS

Quantities and Dates:

Spring Grove State Hospital - since 1873, 108 drawers and 370 boxes (532 cubic feet)
Springfield State Hospital - since 1896, 248 drawers (372 cubic feet)
Rosewood State Training School - since 1887, 180 drawers (270 cubic feet)
Eastern Shore State Hospital - since 1915, 64 drawers (96 cubic feet)
Crownsville State Hospital - since 1912, 67 drawers and 114 cubic feet (214 cubic feet)

1. RECORDS PRIOR TO 1940

This item applies to the medical records of patients discharged or deceased prior to 1940 at:

Spring Grove State Hospital
Rosewood State Training School
Springfield State Hospital
Eastern Shore State Hospital

and those prior to 1950 at:

Crownsville State Hospital

Individual Case Folders containing records of patients are used in

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7. Agency, Division or Bureau Representative

Clifton T. Perkins M.D. — Signature
Commissioner — Title
November 29, 1956 — Date

Schedule Authorized as Indicated in Col. 6 by Hall of Records Commission.

12/5/56 — Date
Marion S. Radcliff — Archivist

Disposal Authorized as Indicated in Col. 6 by Board of Public Works.

DEC 18 1956 — Date
J. McSherry — Secretary

4. Item	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

all mental institutions. Some of the very early records are in bound volumes, many of which are badly mutilated. Up to about 1925, material in the individual folders contains very sketchy information, usually nothing more than a brief description of the patient at the time of admission. After 1925 the record material increases in volume; however, only a small percentage of this has any continuing legal, medical, or research value prior to 1950 at Crownsville and prior to 1940 at the other institutions. The recommendation for this item applies only to the Patients' Case Records prior to those dates, including the earlier bound volumes. Listed below are the records to be retained permanently on microfilm:

Commitment Papers
Doctors' Notes
Discharge or final parole certificate
Death certificate
Court orders
Face Sheet and/or statistical data sheet

It should be noted that not all of these documents are in each folder and occasionally none of them. In cases where none of the permanent records are in the folder, information on the face of the folder will be microfilmed. Information on the face of the folder shows patient's name, case number, diagnoses, date of admission, home address, nearest relative, and date of discharge or death.

RECOMMENDATION: MICROFILM PATIENTS' MEDICAL RECORDS LISTED ABOVE PRIOR TO 1940 AT SPRING GROVE, SPRINGFIELD, AND EASTERN SHORE STATE HOSPITALS AND ROSEWOOD STATE TRAINING SCHOOL, AND PRIOR TO 1950 AT CROWNSVILLE STATE HOSPITAL; RETAIN MICROFILM COPIES PERMANENTLY AND DESTROY THE ORIGINALS AND ALL OTHER DOCUMENTS.

Items 2 through 11, following, apply to the Patients' Medical Records since 1940 at:

Spring Grove State Hospital
Rosewood State Training School
Springfield State Hospital
Eastern Shore State Hospital

and those since 1950 at:

Crownsville State Hospital

Since 1950 at Crownsville and 1940 at the other institutions the individual medical folders contain many records having very

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4. Item	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

little value shortly after the action they report has taken place. The great volume of this material hampers the physicians, nurses, and other staff members in their services to the patient. Furthermore, this tremendous mass of documentation discourages legitimate medical and medico-legal research. To reduce the bulk of the records, thereby making them more accessible for medical, legal, research, and administrative purposes, the content of the folder has been separated into several categories as noted in Items 2 through 11, and recommendations made for the disposition of each category. The records are discussed in general terms rather than as specific forms. This is necessary because the information is recorded on different forms filed in different places, and terminology varies among the hospitals.

2. PERMANENT RECORDS

Commitment Papers
Doctor's Diagnosis and Summaries
Physical Examination
Statistical Data Sheets
Progress Notes
Doctor' Orders
Psychological Test Report (or summary)
Court Orders
Discharge Certificate or final Parole Certificate
(for other parole papers see Item 10 below)
Death Certificate
Laboratory Reports Summary - where not included in the Progress Notes

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Schedule 276, Item 2, Patients Medical Records
Ignore the Recommendation for Permanent Retention and follow procedure as shown below:

A. Discharges, retain for five years after discharge, microfilm and destroy original papers

B. Deaths, retain for three years after death, microfilm and destroy originals

Retain microfilm permanently

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1951 Edition).

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FORM HR-RM 1A
(9-1-53)
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REQUEST FOR RECORDS RETENTION SCHEDULE
(Continuation Sheet)

SCHEDULE NO. 276

PAGE NO. 4.

4. Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.

4. CORRESPONDENCE

Correspondence in the Patient's Folder is readily placed in two classes, that which is of legal or administrative importance, and the other of very limited value. The latter is for the most part with members of the patient's family requesting interviews, acknowledging receipt of clothing, money, etc.

RECOMMENDATION: RETAIN FOR THREE YEARS, THEN REMOVE AND RETAIN PERMANENTLY THAT CORRESPONDENCE HAVING CONTINUING LEGAL OR ADMINISTRATIVE VALUE AND DESTROY ALL OTHER CORRESPONDENCE.

5. SOCIAL SERVICE NOTES AND SUMMARIES

The notes are extremely voluminous at some of the institutions at present and will be at all of them as this program expands. Pertinent information on the notes are summarized and included in the Medical Record.

A. RECOMMENDATION - SOCIAL SERVICE NOTES: RETAIN FOR THREE YEARS AND THEN DESTROY.

B. RECOMMENDATION - SUMMARY OF SOCIAL SERVICE NOTES: RETAIN UNTIL DEATH OR DISCHARGE OF PATIENT AND FOR THREE YEARS THEREAFTER; THEN DESTROY.

6. LABORATORY REPORTS

Information indicated on the Laboratory Report is noted in the Progress Notes or Laboratory Summary Sheet if the information warrants it. If the Laboratory Report shows no noteworthy results the report has no particular value.

RECOMMENDATION: RETAIN LABORATORY REPORTS WHICH HAVE BEEN SUMMARIZED ELSEWHERE ON PERMANENT RECORDS FOR THREE YEARS AND THEN DESTROY.

7. PERSONAL PROPERTY RECEIPT

This form shows all property belonging to the patient which is brought into the hospital.

RECOMMENDATION: RETAIN UNTIL DEATH OR DISCHARGE OF PATIENT AND FOR THREE YEARS THEREAFTER AND THEN DESTROY.

8. TRANSFER FORM (WITHIN HOSPITAL)

This form is used for administrative control in transferring a patient from building to building or service to service within the

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